Double-blind controlled trials of topical acyclovir in primary genital herpes have shown a shorter period of viral shedding, less pain and faster healing of lesions compared with findings in controls. No significant difference was observed in these data, however, in patients with the recurrent form of herpes simplex. Because of this and the potential for resistant strains of the virus emerging, it has been advised that acyclovir not be given topically for recurrent genital herpes.

Preliminary studies of orally given acyclovir have generally shown reduced periods of viral shedding, time to crusting and time to complete healing in patients with primary herpes simplex. But whereas symptomatic recurrences of herpes can be successfully suppressed by taking the drug, oral administration of acyclovir did not prevent later recurrence of disease. Intravenous use of acyclovir is selectively indicated for treating a severe first episode of herpes because viral shedding is reduced from an average of eight to two days; likewise, the drug represents a substantial advance in the care of immunosuppressed patients with the recurrent form of mucocutaneous herpes.

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Diagnosis of Primary Melanoma

ALTHOUGH it is much feared, malignant melanoma is almost completely curable if diagnosed early. Fortunately it most often occurs in superficial locations and has a characteristic appearance. It generally arises de novo on otherwise normal skin, albeit a significant number of lesions arise in preexisting nevi. There are several useful clinical signs that should alert a physician to the possibility of such a tumor. These include changes in size, border and surface and irregular color.

Any irregularly pigmented lesion is suspicious. Most superficial spreading melanoma, which accounts for more than 70 percent of such lesions, will show not only brown and black but also varying shades of red, white and blue. White relates to areas of regression in a tumor, whereas red is due to inflammation. Blue discoloration is more ominous because it suggests pigment present deeper in the dermis. Nodular melanoma is often uniformly bluish black, slate gray or bluish red. Early in their course, lentigo maligna melanoma and acral lentiginous melanoma often have only enlarging brownish discoloration and later show the other characteristic colors.

Most melanoma spreads slowly on the surface of the skin. The initial erratic growth creates an irregular border. The periphery of the lesions is angulated, indented or notched. This is often the first clue. An exception is nodular melanoma, which is smooth margined.

Irregularity of surface is also seen in relatively early lesions. Areas of scale or alteration in surface skin markings may be noted. Most benign nevi are less than 1 cm in diameter. Lesions larger than this or those showing any of the above signs are suggestive.

If diagnosed early, melanoma is amenable to curative surgical treatment more limited in extent than previously thought. Waiting for the late signs such as bleeding, crusting, ulceration or nodule formation will result in a poor prognosis.

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Kaposi's Sarcoma: Current Trends

IN 1872 Moritz Kaposi described the occurrence of smooth reddish skin nodules in six men. The characteristics of the disease, later to be named Kaposi's sarcoma, included a predilection for the lower extremities, multifocal presentation with lesions in the viscera and histologic features characterized by hemorrhage and hemosiderin deposition. This classic form of Kaposi's sarcoma is now known to occur most frequently in elderly men of Italian or Jewish descent and to be characterized by chronic indolent nodules on the lower extremities accompanied by lymphedema.

Almost 100 years after Kaposi's original description, two other groups were found to be susceptible to this disease. Kaposi's sarcoma occurs relatively frequently in equatorial Africa, accounting for 9 percent of malignant conditions in Uganda. In addition to the indolent variety, several aggressive forms with extensive lymph node involvement have been identified in African blacks. A similarly fulminant type of Kaposi's sarcoma has been described in patients with renal transplants and in those receiving immunosuppressive therapy.

In July 1981 the Centers for Disease Control reported cases of Kaposi's sarcoma among homosexual men. Many patients were reported to have had an illness characterized by fever, weight loss and lymphadenopathy preceding the appearance of skin lesions. This fulminant form of Kaposi's sarcoma is occurring in persons with immunosuppression as manifested by cutaneous anergy, the presence of opportunistic infections such as *Pneumocystis carinii* pneumonia, lymphopenia and a decreased ratio of circulating T helper-to-T suppressor lymphocytes. A similar syndrome has been identified in Haitians and intravenous drug abusers.

The current epidemic has sparked numerous investigations. The neoplastic cell is probably derived from vascular endothelium as has been shown by immunoperoxidase staining for factor VIII, a vascular endothelial marker. In addition, a pathogenic role for cytomegalovirus has been suggested by the finding of cytomegalovirus antigens in tumor tissue by immunofluorescence and by the identification of cytomegalovirus RNA in tumor cells by in situ cytohybridization. This epidemic provides a unique opportunity to further in-